Medicare Part D Prescription Plan Worksheet

This worksheet provides the necessary information that SHIP volunteers and staff need to prepare a personalized comparison report for you. *TN SHIP does not endorse any Medicare Advantage or Part D Prescription Drug Plan. Any information provided on this form will not be sold, shared, or used for any other purpose besides providing you with a plan comparison..*

Please remit to: TCAD, TN SHIP, 502 Deaderick Street, 9th Floor, Nashville, TN 37243; Fax: (615) 741-3309; Email: tn.ship@tn.gov

Name: _____ Date of Birth: _____ /_____ /_____
(Please provide your name as it appears on your Medicare Card)

Address: _____
(Please provide the address and zip code you have on file with SSA)

City: _____ State: _____ Zip: _____

Phone: _____ County: _____

Email Address: _____
(Be sure to include if you would like an email response)

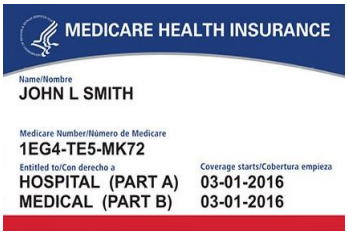
If you would like a personalized search and already have a Medicare.gov account, please provide your account information below.

Username : _____

Password: _____

If you do not have a Medicare.gov account, or are not sure, please provide your Medicare information below so that we can look you up. An account can be created for you if you like. *We will provide you with this information.*

Medicare Number: (full number required)	
Part A Start Date:	
Part B Start Date:	



Do you have any of the following coverages?

Medicaid/TENNCARE?	☐ YES	☐ NO	Retiree Insurance?	☐ YES	☐ NO
TRICARE or VA?	☐ YES	☐ NO	Federal Employee Health?	☐ YES	☐ NO

Do you currently have Part D Drug Coverage? YES ☐ NO ☐ **Is this an advantage plan?** YES ☐ NO ☐
If so, what is the name of your current plan? *You should be able to get this from your card.*

_____

Are you interested in changing the type of plan that you are on? YES ☐ NO ☐
(moving from Part D to an Advantage plan or moving from Advantage to Original Medicare)
How would you like to get your comparison? _____
(postal mail, email, phone call)

"This project was supported, in part by grant number 90SAPG0069-02-00, 2001TNMISH-00, 2001TNMIAA-00, and 2001TNMIDR-00, from the U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C. 20201. Grantees undertaking projects with government sponsorship are encouraged to express freely their findings and conclusions. Points of view or opinions do not, therefore, necessarily represent official ACL policy."

Does any of the following apply to you?

The state pays my Part B premium.

YES ☐ NO ☐

I already qualify for and receive Extra Help with my prescription costs.

YES ☐ NO ☐

I would like help applying for assistance programs to help with the costs of Medicare.

YES ☐ NO ☐

If you agree that you would like help applying for assistance, a TN SHIP staff member or volunteer will reach out to you to start the screening process. There are several programs available if you qualify.

Is your household's total gross income below $1,615 if single, $2,174 if married?

Total income from all sources? _____

What is your total assets and resources? _____

(Do not include your residence or vehicle)

Do you currently take prescription medications? *If so, please list in the chart below. Add a page if more space is needed.*

YES ☐ NO ☐

What is your preferred pharmacy and location _____

Would you be interested in information about pharmacies that may be cheaper?

YES ☐ NO ☐

Do you get your medications through mail order?

YES ☐ NO ☐

Name of Medication	Generic ok? Y/N	Strength/Dosage	Frequency	How often do you refill this medication?
Example: Lipitor	*no*	*Example: 20 mg*	*Example: 30 or one per day*	*Example: 90 day supply*

TN SHIP USE ONLY

Counselor Name_____ **Date of Comparison** _____/_____/_____

Changed/enrolled in a different plan? YES ☐ NO ☐ **Name of plan?**_____

Part D Outcomes: Original plan cost? _____ **New Plan cost?** _____ **Savings?** _____

Comparison and Enrollment Confirmation uploaded to STARS? YES ☐ NO ☐